Minnesota BOARD OF Nursing

2829 University Avenue SE #200
Minneapolis, MN 55414-3253
(612) 317-3000 – Voice (612) 617-2190 – Fax
Toll Free (888) 234-2690 (MN, IA, ND, SD, WI)
(800) 627-3529 – TTY
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

Reregistration Instructions

If you have been licensed in Minnesota but have not renewed, reregistration is the process by which you reactive your license. Requirements vary depending on how long your registration has been expired and how long it has been since you last practiced nursing. You must:

- Submit a *Reregistration Application* form and fee. You can print the form from the Board's website or access the online reregistration application by clicking on the Online Services button and logging into your licensee account.
- Submit a *Confirmation of Nursing Employment for Reregistration* form.

You may also have to complete and report continuing education. If you have not practiced nursing for five years or more, you are required to take a nurse refresher course.

When your complete application is received, the Board will inform you whether to report continuing education hours and whether you are required to take a nurse refresher course.

Date: 8/1/2013

All fees are nonrefundable

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REREGISTRATION APPLICATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine eligibility for reregistration of your license; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications. All data submitted on the application, except social security number and responses to grounds for denial questions, is public. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

INSTRUCTIONS

If you have been licensed in Minnesota but have not renewed, reregistration is the process by which you reactivate your license. Requirements vary depending on how long your registration has been expired and how long it has been since you last practiced nursing. You must submit an application, fee, and confirmation of nursing employment form. You may also have to complete and report continuing education. If you have not practiced nursing for five years or more, you are required to take a nurse refresher course. When your complete application is received, the Board will inform you whether to report continuing education hours and whether you are required to take a nurse refresher course.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS	CITY	
STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
MINNESOTA LICENSE NUMBER ☐ RN _____ ☐ LPN_____		
E-MAIL ADDRESS	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female

UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72	☐ I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number	MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72
___ ___ ___ - ___ ___ - ___ ___ ___ ___		___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

BUSINESS ADDRESS: Minn. Stat. Sec.214.073 requires licensees to provide their primary business address at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.

FACILITY NAME		
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE

☐ I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.

ADVANCED PRACTICE REGISTERED NURSE

I am currently certified as an advance practice registered nurse. My certification is as a:

☐ Certified Clinical Nurse Specialist – *include copy of current certificate.*
☐ Certified Nurse-Midwife – *include copy of current certificate.*
☐ Certified Registered Nurse Anesthetist – *include copy of current certificate.*
☐ Certified Nurse Practitioner – *include copy of current certificate.*

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GROUNDS FOR DENIAL Provide a written explanation for every YES response.		
1.	☐ Yes ☐ No	Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or county?
2.	☐ Yes ☐ No	Have you ever violated a state or federal rule relating to narcotics or controlled substances or other similar regulations?
3.	☐ Yes ☐ No	Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony, gross misdemeanor or misdemeanor offense? NOTE: The fact that a conviction has been pardoned, expunged, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."
4.	☐ Yes ☐ No	In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
5.	☐ Yes ☐ No	Have you been fired from a nursing-related job in the last five years due to conduct that may be grounds for disciplinary action under the Nurse Practice Act?
6.	☐ Yes ☐ No	Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a nursing license or any other occupational license in any state, territory or country?
7.	☐ Yes ☐ No	Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety? **Provide a statement explaining management and treatment**. NOTE: If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question
8.	☐ Yes ☐ No	Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid?

NURSING PRACTICE

Have you ever practiced nursing? ☐ Yes ☐ No If yes, complete this section no matter how long ago you practiced nursing. This information will be used to determine if you must report continuing education, and if so, how many hours.

Nursing practice is employment or volunteer work which required a current nursing license. It is important you report only a position that **required** you to be a nurse. Your last date of practice might not be the last date of employment, for example you were on vacation or a leave of absence and did not practice nursing.

NAME OF INSTITUTION	STATE IN WHICH PRACTICE OCCURRED

FEDERAL FACILITY ☐ YES ☐ NO	LAST DATE OF NURSING PRACTICE (mm/dd/yyyy)

Are you applying for reregistration in Minnesota solely for the purpose of licensure in another state? ☐ Yes ☐ No
If yes, send a verification of licensure request and a separate $20 check, payable to the Minnesota Board of Nursing with the application for reregistration and fee.

FEE CALCULATION

Have you practiced nursing in Minnesota after your registration expired? ☐ Yes ☐ No If yes, state number of months or part(s) of months during which you practiced without current registration _____. Use the penalty fee schedule below to determine the fee amount that you owe. **The penalty fee must be paid in the form of a certified check or money order and submitted at the time you submit your reregistration application.**

Penalty Fee Schedule for Practicing Without Current Registration

Month(s) Worked	Penalty Fee	Months Worked	Penalty Fee	Months Worked	Penalty Fee	Months Worked	Penalty Fee
1	$170.00	7	$680.00	13	$1,190.00	19	$1,700.00
2	$255.00	8	$765.00	14	$1,275.00	20	$1,785.00
3	$340.00	9	$850.00	15	$1,360.00	21	$1,870.00
4	$425.00	10	$935.00	16	$1,445.00	22	$1,955.00
5	$510.00	11	$1,020.00	17	$1,530.00	23	$2,040.00
6	$595.00	12	$1,105.00	18	$1,615.00	24	$2,125.00

FEE AMOUNT REQUIRED:

☐ $115.50 ($105.00 Reregistration Fee and $10.50 eLicensing surcharge per MN Statute Sec.16E.22)

☐ $_____Penalty Fee (money order/cashier's check only)

$_____ **TOTAL ENCLOSED** (All fees are nonrefundable)

I affirm that the statements and documents provided by me during the application process are true and correct.

Legal Signature of Applicant	Date (mm/dd/yyyy)

Return completed form and nonrefundable applicable fee(s) in U.S. funds to Minnesota Board of Nursing

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CONFIRMATION OF NURSING EMPLOYMENT FOR REREGISTRATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine eligibility for reregistration of your license; enable us to contact you when necessary; and identify you. All data submitted on the application is a public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

• **Type or print clearly** • **Use black ink** • **Provide all information** •**Incomplete forms will be returned** • **Do not use initials or abbreviations**

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
MINNESOTA LICENSE NUMBER ☐ RN _____ ☐LPN_____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
E-MAIL ADDRESS		
LAST DATE OF NURSING PRACTICE (mm/dd/yyyy)	TYPE OF PRACTICE ☐ EMPLOYMENT IN NURSING ☐ VOLUNTEER NURSING	
LEGAL SIGNATURE OF APPLICANT	DATE (mm/dd/yyyy)	

• **SEND THIS FORM TO AN EMPLOYER FOR WHOM YOU HAVE WORKED AS A NURSE.** If you did not have an employer, a patient, volunteer supervisor, patient's family or physician, or a peer may verify nursing practice. This form must verify your most recent date of nursing practice.

NURSING PRACTICE

NOTE: Verify this person's practice as nursing practice only if the person was employed or volunteered as a licensed registered nurse or licensed practical nurse or if the position required a license as a nurse.

This person: ☐was employed as a nurse — last date of practice as a nurse (mm/dd/yyyy): _____

☐volunteered as a nurse — last date of practice as a nurse (mm/dd/yyyy): _____

☐is currently employed as a nurse. — last date of practice as a nurse (mm/dd/yyyy): _____
If the nurse is currently employed, this date must be filled in. Please do not write "Current."

This person practiced as a: ☐Registered Nurse ☐Licensed Practical/Vocational Nurse

State in which practice occurred: _____

NAME OF INSTITUTION OR AGENCY	FEDERAL FACILITY/AGENCY ☐Yes ☐ No
STREET ADDRESS	CITY, STATE, ZIP CODE
SIGNATURE	TITLE